Cabinet for Health and Family Services
Department for Medicaid Services
Frankfort KY 40621

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The Community Mental Health - Mental Retardation
Reimbursement Manual
(July 2005 edition)

Filed:

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES
COMMUNITY MENTAL HEALTH-MENTAL RETARDATION
REIMBURSEMENT MANUAL

PART I

GENERAL POLICIES AND GUIDELINES

Cabinet for Human Resources
275 East Main Street
Frankfort, Kentucky 40621

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TABLE OF CONTENTS

SECTION 100 - INTRODUCTION

The Principles of Reimbursement which follow include provisions which specify the allowable costs to be recognized in determining reimbursement for covered services rendered program eligibles. For Title XIX, these principles are supplemented by Title XVIII (Medicare) Principles of Reimbursement with regard to allowable costs and limitations on costs for those areas or issues which are not specifically set forth in this manual.

A review mechanism has been provided so that upon receipt of the Department's determination of program reimbursement, the community mental health-mental retardation center may request a review of the determination through the provisions set forth in the Principles of Reimbursement in this manual.

SECTION 100 - INTRODUCTION

100. INTRODUCTION:

The objective of the Department for Medicaid Services (DMS) is to assure quality health care and social services to eligible beneficiaries. Support for comprehensive mental health-mental retardation services within the community has been demonstrated through the Cabinet's reimbursement of covered services through community mental health-mental retardation centers as defined under Kentucky licensure regulations and further qualified by Title XIX policies.

The General Policies and Guidelines and Principles of Reimbursement set forth in this manual specify the conditions, requirements, limitations and method of reimbursement for community mental health-mental retardation centers for services rendered to Title XIX recipients. The Cabinet has determined that the most feasible method of reimbursement for the Title XIX Program is a prospective payment which would reflect reasonable allowable costs and require no year-end settlement. Therefore once the current system is fully implemented as of July 1, 1993, payments shall be made on a total prospective basis.

SECTION 101 - SCOPE OF SERVICES

101. SCOPE OF SERVICES:

The Community Mental Health-Mental Retardation Center. licensure regulation provides the basis for designation as a community mental health-mental retardation center. The Title XIX Program regulations reinforce these licensure requirements but provide certain limitations with respect to reimbursable services. The scope of services shall be specified for Title XIX by the Community Mental Health Center Program Manual.

102. REQUIREMENTS AND LIMITATIONS OF PARTICIPATION:

To participate as a reimbursable mental health-mental retardation provider under the Title XIX Program, each community mental health-mental retardation center shall be licensed by the appropriate state agencies.

When a community mental health-mental retardation center elects to participate in the Title XIX Program, the allowable cost, as defined, of all services provided in accordance with the requirements specified by the Community Mental Health-Mental Retardation Center Program regulation shall be included as a reimbursable cost of the participating community mental health-mental retardation center up to the maximum established by the program. All covered services, including staff physician services, shall be reimbursed through the community mental health-mental retardation center payment mechanism.

SECTION 103 - METHOD OF REIMBURSEMENT

103. METHOD OF REIMBURSEMENT:

Utilizing the provisions for allowable costs and limitations as set forth in this manual, the method of reimbursement utilizes billable service units, payment rates and annual cost reports.

A billable client service is a unit of service based on time, which consists solely of a face-to-face contact in rendering a service.

Unit of Service Definitions

1 Client Day	- A day begins at Midnight and ends 24 hours later. A part of admission counts as a full day. However, the day of discharge or death, or a day on which a client begins a leave of absence, is not counted as a day.
1 Client Hour	- A client hour starts at the time the face-to-face contact starts and ends 60 minutes later.
1/4 Client Hour	- A quarter hour starts at the time the face-to-face contact starts and ends 15 minutes later.
1/4 Staff Hour	- A quarter hour staff hour starts at the time the service begins and ends 15 minutes later.
1 Staff Hour	- A staff hour starts at the time the service begins and ends 60 minutes later.

SECTION 103 - METHOD OF REIMBURSEMENT

With the exception of the Client Day Unit of Service, partial units shall be rounded to the nearest whole unit of service.

For outpatient services, statistics shall be kept on both client hours and staff hours.

A community mental health-mental retardation center billable service is a unit of time rendered by a psychiatrist, psychologist, psychiatric nurse, master degree social worker or an individual with equivalent professional education as defined by the Cabinet.

SECTION 106 – RATE SETTING FOR STATE FISCAL YEAR 2005

Effective July 1, 2004, the State Fiscal Year (SFY) 2005 Mental Health Center services payment rate shall remain the same as the rate in effect on June 30, 2002 and there shall be no cost settling. Any language in this manual which may contradict the prior sentence shall not be effective for SFY 2005.

SECTION 106A – RATE SETTING FOR STATE FISCAL YEAR 2006

Effective July 1, 2005, the community mental health center services payment rates that were in effect on June 30, 2002 through June 30, 2005 shall remain in effect through SFY 2006 and there shall be no cost settling. Any language in this manual which may contradict the prior sentence shall not be effective for SFY 2006.

SECTION 107 - UTILIZATION REVIEW

107. UTILIZATION REVIEW:

If deemed necessary to assure appropriate utilization, systems of utilization review for determining norms and upper limitations and acceptable deviations from such standards shall be established. These systems shall be used to identify possible abuse of the payment system and to prospectively inform providers of the promulgation of such limitations.

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES
COMMUNITY MENTAL HEALTH-MENTAL RETARDATION
REIMBURSEMENT MANUAL

PART II

PRINCIPLES OF REIMBURSEMENT

Cabinet for Human Resources
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TABLE OF CONTENTS

TABLE OF CONTENTS

TABLE OF CONTENTS

SECTION 200 - INTRODUCTION

200. INTRODUCTION:

(A) Community mental health-mental retardation centers shall be reimbursed by the Department for Medicaid Services (DMS) for providing covered services to eligible clients.

(B) The principles of reimbursement and the related policies establish the guidelines and procedure to be used in determining reasonable allowable cost.

(C) The principles of reimbursement are to be applied by the Cabinet in the payment of claims.

(D) The principles of reimbursement are written for treatment under the Title XIX Program.

(E) An important role of the Department, in addition to claims processing, payment and program administration, is to furnish technical assistance to providers in the development of accounting and cost finding procedures which shall assure them equitable payment under all programs.

SECTION 201 - COST REIMBURSEMENT - GENERAL

201. COST REIMBURSEMENT - GENERAL:

(A) Payment is to be made on the basis of the projected current year reasonable allowable costs of the individual provider. This shall be achieved through a reimbursement program based on reasonable and allowable costs through a payment system as defined in Section 205. All expenses of a provider in the production of services shall be necessary and proper to be considered reasonable and allowable. The share of the total provider cost that is borne by Title XIX is related to the services furnished beneficiaries so that no part of their cost would need to be borne by other patients. Conversely, costs attributable to other patients of the provider are not to be borne by Title XIX. The application of this approach, with appropriate accounting support, shall result in meeting the actual reasonable allowable costs of services to beneficiaries in light of such costs of similar providers. However, payments to providers for services rendered program beneficiaries are subject to the provisions of Sections 219 and 220.

(B) As formulated herein, the principles give recognition to such factors as depreciation, interest, certain educational costs, and compensation of owners. With respect to allowable costs, some items of inclusion and exclusion are:

(1) Depreciation is an allowable cost. An historical cost basis shall be used. Only assets actually in use for production of services for program beneficiaries shall be recognized. A use allowance may be negotiated for fully depreciated assets. The funding of depreciation is encouraged to provide necessary replacement of assets.

(2) Interest costs are allowable costs.

(3) Bad debts', charity, and courtesy allowances are not allowable costs.

(4) An appropriate part of the net cost of staff training and continuing professional educational activities on other than a full time basis are allowable costs.

(5) Costs incurred for research purposes are allowable costs.

(6) Grants, gifts, and income from endowments shall not be deducted from allowable costs unless they are designated by the donor for the payment of specific costs.

(7) The value of services provided by non-paid workers, as members of an organization (including services of members of religious orders) having an agreement with the provider to furnish such services, is not an allowable cost.

(8) Discounts and allowances received on the purchase of goods or services are reductions of the cost to which they relate.

(9) The costs associated with political contributions are not allowable costs.

(10) The costs associated with legal fees for unsuccessful lawsuits against the Cabinet are not allowable costs. Legal fees relating to lawsuits against the Cabinet shall only be included as allowable costs in the period in which the suit is settled after a final decision has been made that the lawsuit is successful, or when otherwise agreed to by the parties involved, or ordered by the court.

(11) The cost associated with any necessary legal expense incurred in the normal administration of the program is an allowable cost; however, the cost of legal fees incurred for judgments granted as a result of unlawful pursuits or purposes is unallowable.

(12) The costs for travel and associated expenses outside the Commonwealth of Kentucky for purposes of conventions, meetings, assemblies, conferences or any related activities are not allowable costs. However, costs (excluding transportation costs) for training or educational purposes outside the Commonwealth of Kentucky are allowable costs. Even though such meetings per se are not educational, costs (excluding transportation) are allowable if educational or training components are included.

(13) Costs of patient transportation are allowable.

(14) The costs of motor vehicles used by management personnel shall be allowed up to fifteen thousand dollars ($15,000) total valuation per agency, adjusted annually for inflation. Cost exceeding this limit is not allowable, except when such cost is considered as compensation.

SECTION 202 - APPORTIONMENT OF ALLOWABLE COSTS

202. APPORTIONMENT OF ALLOWABLE COSTS:

(A) Reimbursement under the program involves a determination of (1) each provider's allowable costs of providing services, and (2) the share of these costs which is to be borne by the funding program. The provider's allowable cost are to be determined in accordance with the principles described in Section 201 relating to reasonable allowable costs. The share to be borne by the program is to be determined in accordance with principles set forth in this section, relating to apportionment of costs.

(B) The objective is to adopt methods that would, to the extent reasonably possible, result in a program's share of a provider's total allowable costs being the same as a program's share of the provider's total services.

(C) A method of cost reimbursement used for the reimbursement of clinic services apportions a provider's total allowable costs in specified direct service departments or centers among groups served on the basis of the relative number of covered units of service in each of these departments or centers. This method results in an average departmental cost per unit of service. It is presumed that a program beneficiary in his use of services is typical of the patients receiving services of a

community mental health-mental retardation center and is, therefore, typical from the standpoint of average departmental cost.

(D) The method of "cost-finding" recommended is such that the provider's costs are accumulated by functional service components, departments or cost centers (whether revenue producing or non-revenue producing), which provide a general classification of related services. All costs of general service departments that serve as support to direct service departments shall be allocated to those direct service departments based upon the cost allocation methodology contained in the annual cost report; or on a functional basis (some statistics reflective of actual usage); or based upon direct costing (direct identification of the cost center benefiting from a particular expenditure). A provider utilizing functional or direct costing shall do so on a consistent basis.

203. FINANCIAL DATA AND REPORTS:

(A) General. The principles of cost reimbursement require that providers maintain sufficient financial records and statistical data for proper determination of costs payable under the programs. Essentially the methods of determining costs payable under the programs involve making use of data available from the provider's basic accounts to arrive at equitable and proper payment for services to beneficiaries.

(B) Cost Reports. For cost reporting purposes, the Cabinet requires each provider of services to submit periodic reports of its operations which cover a consecutive twelve month period. Amended cost reports to revise cost report information which has been previously submitted by a provider may be permitted or required as determined by the Cabinet.

(C) Due Dates for Cost Reports. Cost reports are due on or before the last day of the second month (60 days) following the close of the period covered by the report. There shall be no automatic extension of time for the filing of the cost report. However, providers may request a thirty (30) day extension of time when circumstances jeopardize timely filing. Such an extension shall be requested in writing five (5) days prior to the date the cost report is due. The request shall be addressed to the Director, Division of Reimbursement Operations, Department for Medicaid Services. Payments to the provider may be suspended until an acceptable cost report is filed with the Cabinet.

(D) Recordkeeping Requirements for New Providers. A newly participating provider of services shall, upon request, make available to the Department for examination its fiscal and other records for the purpose of determining such provider's ongoing recordkeeping capability and inform the Department of the date its initial cost reporting period shall end. This examination is intended to assure that (1) the provider has an adequate ongoing system for furnishing the records needed to provide accurate cost data and other information capable of verification by qualified auditors and adequate for cost reporting purposes, (2) the provider's financial statements are audited and reported upon by a certified public accountant, and (3) no financial arrangements exist that shall obstruct the intent of the Cabinet to reimburse providers in accordance with guidelines contained herein. The data and information to be examined include cost, revenue, statistical, and other information pertinent to reimbursement.

(E) Providers Without a Full Year's Experience. Providers that have recently opened for business, or who have just begun participation in one or more programs and do not have twelve months of actual experience, shall file a projected twelve month cost report. This report shall consider actual costs and units of service, in each specific service department that have occurred since the opening of the center and project costs and units of service for the twelve month period taking into consideration known factors. This projected cost

report shall be reviewed to determine the reasonableness of the estimate. Adjustments shall be made if necessary in light of the experience of similar providers.

(F) Fiscal Year. All providers shall utilize a June 30 fiscal year end for cost reporting purposes.

(G) Continuing Provider Recordkeeping Requirements. The provider shall furnish such information to the Cabinet as may be necessary to assure proper payment by the Cabinet including the extent to which there is any common ownership or control between providers or other organizations.

(H) Time Record Requirements. Personnel costs identified with individual cost centers, whether considered direct or indirect costs, shall be based on payrolls documented and approved in accordance with sound management practices and standard cost accounting methods. Payrolls shall be supported by time and attendance (or equivalent)

records utilizing 100% time distribution for individual employees or other methods approved by the Cabinet.

(I) Access to Provider Records. The provider shall permit the Cabinet to examine such records and documents as are necessary to ascertain information pertinent to the determination of the proper amount of program payments due. These records shall be kept by the provider for a period of not less than three years, or until audit resolution, and shall include, but not be limited to: (1) matters of provider ownership, organization, and operation; (2) minutes of meetings of Board of Directors and committees; (3) fiscal, patient treatment and other record keeping systems; (4) federal income tax returns; (5) matters relating to asset acquisition, lease, sale or other dispositions; (6) franchise or management arrangements including costs of parent or "home office" operations; (7) client service charge schedules; (8) all matters pertaining to cost of operation; (9) amounts of income received by source and purpose; and (10) the flow of funds and working capital.

(J) Suspension of Program Payments to a Provider. When the Cabinet determines that a provider does not maintain or no longer maintains adequate records for the determination of reasonable cost under the program, either payments to such provider shall be suspended until the Cabinet is assured that adequate records are maintained, or the Cabinet may elect to set in motion the provisions as outlined in

SECTION 203 - FINANCIAL DATA AND REPORTS

KRS 210.440. Before suspending payments to a provider, the Cabinet shall send written notice to such provider of its intent to suspend payments. Moreover, any overpayment which may have occurred after the close of the provider's reporting period, but prior to the setting of a new rate as a result of the provider's failure to maintain adequate records, shall be recovered by the Cabinet. The notice shall explain the basis for the Cabinet's determination with respect to the provider's records and shall identify the provider's recordkeeping deficiencies. The provider shall be given the opportunity to submit a statement (including any pertinent evidence) as to why the suspension shall not be put into effect.

SECTION 204 - ADEQUATE COST DATA AND COST FINDING

204. ADEQUATE COST DATA AND COST FINDING:

(A) Principle. Providers receiving payment on the basis of reimbursable cost shall provide adequate cost data. This shall be based on their financial and statistical records which shall be capable of verification by qualified auditors. The cost data shall be based on an approved method of cost finding and, unless otherwise specified, on accounting methods which are in conformity with generally accepted accounting principles. However, where governmental institutions operate on a cash basis of accounting, cost data based on such basis of accounting shall be acceptable subject to appropriate treatment of capital expenditures.

(B) Definitions.

(1) Cost Finding. Cost finding is the process of recasting the data derived from the accounts ordinarily kept by a provider to ascertain costs of the various types of services rendered. Cost finding is the determination of these costs by the allocation of direct costs and proration of indirect costs.

(2) Accrual Basis of Accounting. Under the accrual basis of accounting, revenue is reported in the period when it is earned regardless of when it is collected, and expenses are reported in the period in which they are incurred regardless of when they are paid.

(3) Prior Approval. Prior approval means that a provider shall secure approval, in writing, of a methodology change prior to implementation. Verbal approval is not acceptable and shall not be considered as prior approval.

(C) Adequacy and Consistency. Adequate cost information shall be provided in sufficient detail in the provider's records to support payments made for services rendered to beneficiaries. In order to provide the required cost data and not impair comparability, financial and statistical records shall be maintained in a manner consistent from one period to another. However, a proper regard for consistency need not preclude a desirable change in accounting procedures when there is reason to effect such change.

SECTION 205 - PAYMENTS TO PROVIDERS: SPECIAL CIRCUMSTANCES

205. PAYMENTS TO PROVIDERS: SPECIAL CIRCUMSTANCES

(A) Prospective Rate Determination for New Providers. When newly established providers do not have twelve months of actual cost. experience on which to base the determination of a prospective rate, the provider shall file a projected twelve month cost report. This report shall be evaluated to determine the reasonableness of the projections and a rate determined relative to the experience of similar providers, maximum rates established by the Program, and other factors.

(B) Rate Determination for a New Service. When a provider implements a new service and does not have twelve months of actual cost experience on which to determine a rate, the provider may file a budgeted report for that service, projecting costs and the number of units of services to be provided. The scope of the service and the projections shall be justified by appropriate narratives and worksheets, and prior approval shall be secured from the Cabinet before a new rate is set. A prospective rate shall be determined on the basis of the lower of the approved projections of the maximum rate established by the Program.

If at the fiscal year end, the provider does not yet have twelve months of actual cost experience for that service, a budgeted report shall again be filed, using actual data when appropriate in arriving at a projection.

(C) Rate Determination for a Change in Service. When a provider implements a change in a service which expands the scope of the service and results in a cost per unit of service increase of more than 20% of the present prospective payment rate, a budgeted report for that service may be filed if twelve months of actual cost experience is not available under the expansion. Projected reports are subject to the same prior approval requirements as outlined in (E) above. An increase in the cost per unit of service which is the result of a decrease from the previous year in the number of services provided, is not considered a change in the scope of services, and the prospective rate shall be determined according to (C) of this section.

(D) Bankruptcy or Insolvency of Provider. If, on the basis of reliable evidence, the Cabinet has a valid basis for believing that, with respect to a provider, proceedings have been or shall shortly be instituted in a State or Federal court for purposes of determining whether such provider is insolvent or bankrupt under an appropriate State or Federal law, any payments to the provider shall be adjusted

by the Cabinet, notwithstanding any other regulation or program instruction regarding the timing or manner of such adjustments, to a level necessary to insure that no overpayment to the provider is made.

SECTION 206 - DEPRECIATION: ALLOWANCE FOR DEPRECIATION BASED ON ASSET COSTS

206. DEPRECIATION: ALLOWANCE FOR DEPRECIATION BASED ON ASSET COSTS:

(A) Principle. An appropriate allowance for depreciation on buildings and equipment is an allowable cost within the limitations specified below. The depreciation shall be:

(1) identifiable and recorded in the provider's accounting records;

(2) based on the historical cost of the asset or, in the case of donated assets, the fair market value at the time of donation;

(3) prorated over the estimated useful life of the asset using the straight-line method; and

(4) any acquisition or improvement of a depreciable asset of at least $500 or an aggregate of $500 with at least a two year life shall be capitalized. Repairs and maintenance to an asset are allowable costs in the current accounting period, except that any repair and maintenance of an asset for $2,500 or an aggregate of that amount during the reporting year shall be capitalized over the remaining useful life of the asset.

(B) Definitions.

(1) Historical Costs. Historical cost is the cost incurred by the present owner in acquiring the asset. For depreciable assets

acquired after June 1, 1978, the historical cost used as the basis for depreciation shall not exceed the lower of current reproduction cost adjusted for straight-line depreciation over the life of the asset to the time of the purchase or fair market value at time of acquisition.

(2) Fair Market Value. Fair market value is the price that the asset would bring by bona fide bargaining between well-informed buyers and sellers at the date of acquisition. Usually the fair market price is the price at which bona fide sales have been consummated for assets of like type, quality, and quantity in a particular market at the time of acquisition.

(3) Current Reproduction Costs. Current reproduction costs is the cost at current prices, in a particular locality or market area, of reproducing an item of property or a group of assets. Where depreciable assets are concerned, this means the reasonable cost to build, reproduce in kind, or in the case of equipment or similar assets, to purchase in the competitive market.

(C) Recording of Depreciation. Appropriate recording of depreciation encompasses the identification of the depreciable assets in use, the asset's historical costs, the method of depreciation, estimated useful life, and the asset's accumulated depreciation. In selecting a proper useful life, the American Hospital Association useful life

guidelines may be used or the provider may assign reasonable lives on a straight line declining balance basis.

(D) Depreciation Methods. Proration of the cost of an asset over its useful life is allowed on the straight-line method.

(E) Funding of Depreciation. The funding of depreciation is encouraged to provide for necessary replacement of fixed assets.

(F) Gains and Losses on Disposal of Assets. Gains and losses realized from the disposal of depreciable assets while a provider is participating with the Cabinet, or within one year of the time the provider terminates participation, are to be included in the determination of allowable cost. The extent to which such gains and losses are includable is calculated on the proration basis recognizing the amount of depreciation charged under Cabinet funding in relation to the amount of depreciation, if any, charged or assumed in a period prior to the provider's participation, and in the period after the provider's participation, when the sale takes place within one year after termination.

(G) Basis of Assets Donated to a Provider. When an asset is donated to a provider, the basis for depreciation of the asset shall be the fair market value of the donated asset at the time of the donation.

(H) Basis of Assets Used Under the Program and Donated to a Provider. Where an asset that has been used or depreciated under the Program is donated to a provider, the basis of depreciation for the asset shall be the lesser of the fair market value or the net book value of the asset in the hands of the owner last participating in the Program. The net book value of the asset is defined as the depreciable basis used under the Program by the asset's last participating owner less the depreciation recognized under the Program.

(I) Amortization of Start-Up Costs. For new service providers or newly established satellite centers of participating providers, proration of start-up costs shall be over sixty (60) months utilizing the straight-line method.

(J) Depreciation of Fully Depreciated or Partially Depreciated Assets.

(1) Principle. Depreciation on assets being used by a provider at the time it enters into participation with the Cabinet is allowed;

this applies even though such assets may be fully or partially depreciated on the provider's books.

(2) Application. Depreciation is allowable on assets being used at the time the provider enters into participation with CHR. This applies even though such assets may be fully depreciated on the provider's books or fully depreciated with respect to other third party payors. As long as an asset is being used, its useful life is considered not to have ended, and consequently the asset is subject to depreciation based on a revised estimate of the asset's useful life as determined by the provider and approved by the Cabinet. Correction of prior year's depreciation to reflect revision of estimated useful life should be made in the first year of participation. When an asset has become fully depreciated under CHR funding, further depreciation would not be appropriate or allowable, even though the asset may continue in use. For example, if a 50 year old building is in use at the time the provider enters into participation, depreciation is allowable on the building even though it has been fully depreciated on the provider's books. Assuming that a reasonable estimate of the asset's continued life is 20 years (70 years from the date of acquisition), the provider may claim depreciation over the next 20 years - if the asset is in use that long - or a total depreciation of as much as twenty-seventieths of the asset's historical cost. If the asset is disposed of before the expiration of its estimated

source's regulations. Moreover, recognition of this cost is necessary to maintain productive capacity for the future. An incentive for funding of depreciation is provided in these principles by the provision that investment income on funded depreciation is not treated as a reduction of allowable interest expense under Section 207(B)(2)(c).

SECTION 207 - INTEREST EXPENSE

207. INTEREST EXPENSE:

(A) Principle. Necessary and proper interest as defined on both current and capital indebtedness is an allowable cost.

(B) Definitions.

(1) Interest. Interest is the cost incurred for the use of borrowed funds. Interest on current indebtedness is the cost incurred for funds borrowed for a relatively short term. This is usually for such purposes as working capital for normal operating expenses. Interest on capital indebtedness is the cost incurred for funds borrowed for capital purposes, such as acquisition of facilities and equipment, and capital improvements. Generally, loans for capital purposes are long-term loans.

(2) Necessary. Necessary requires that the interest:

(a) Be incurred on a loan made to satisfy a financial need of the provider. Loans which result in excess funds or investments would not be considered necessary.

(b) Be incurred on a loan made for the following purposes:

(i.) Represent interest on long-term debt existing at the time the provider enters into participation with the

Cabinet plus interest on new long-term debt, the proceeds of which are used to purchase fixed assets relating to the provision of the appropriate level of care. If the debt is subject to variable interest rates found in "balloon" type financing, renegotiated interest rates subject to tests of reasonableness shall be allowable. The form of indebtedness may include mortgages, bonds, notes, and debentures when the principal is to be repaid over a period in excess of one year.

(ii.) Other interest for working capital and operating needs that directly relate to providing patient care is an allowable cost with the following exception. Short-term interest expense on a principal amount in excess of payments made under the rate equivalent to two months experience based on actual Cabinet funding receivables, shall be disallowed in determining cost. The form of such indebtedness may include, but is not limited to, notes, advances and various types of receivable financing.

(c) Be reduced by investment income except where such income is from gifts and grants, whether restricted or unrestricted, and which are held separate and not commingled with other funds, or have been uncommingled, if necessary. This

does not mean that the funds shall be kept in separate bank accounts, although this may be found to be the easiest method. When investment income is derived from combined or pooled funds, only that portion of investment income resulting from the facility's assets after uncommingling shall be considered in the reduction of interest cost. Income from funded depreciation, a provider's qualified pension fund, or a formal deferred compensation plan is not used to reduce interest expense.

For purposes of this section, monies received from federal or state funding sources shall not be considered gifts or grants. Funds shall be considered sufficiently uncommingled when the following criteria are met:

The source of the gifts and grants shall be identified and documented.

The receipt and disbursement of these funds shall be recorded in separate general ledger accounts (distinguishable by sources of funds).

The balance of these funds in the general ledger accounts shall (at all times) be reconcilable with the investment account balances.

(3) Proper. Proper requires that interest:

(a) Be incurred at a rate not in excess of what a prudent borrower would have had to pay in the money market existing at the time the loan was made.

(b) Be paid to a lender not related through control or ownership, or personal relationship to the borrowing organization. However, interest is allowable if paid on loans from the facility's donor-restricted funds, the funded depreciation accounts, or facility's qualified pension fund.

(C) Borrower-Lender Relationship.

(1) To be allowable, interest expense shall be incurred on indebtedness established with lenders or lending organizations not related through control, ownership, or personal relationship to the borrower. Presence of any of these factors could affect the "bargaining" process that usually accompanies the making of a loan, and could thus be suggestive of an agreement on higher rates of interest or of unnecessary loans. Loans should be made under terms and conditions that a prudent borrower would make in arms-length transactions with lending institutions. The intent of this provision is to assure that loans are legitimate and needed,

and that the interest rate is reasonable. Thus, interest paid by the facility to partners, stockholders, or related organizations of the facility shall not be allowable. Where the owner uses his own funds in a business, it is reasonable to treat the funds as invested funds or capital, rather than borrowed funds. Therefore, where interest on loans by partners, stockholders, or related organizations is disallowed as a cost solely because of the relationship factor, the principal of such loans shall be treated as invested funds.

(2) Exceptions to the general rule regarding interest on loans from controlled sources of funds are made in the following circumstances.

Where the general fund of a provider "borrows" from a donor-restricted fund and pays interest to the restricted fund, this interest expense is an allowable cost. The same treatment is accorded interest paid by the general fund on money "borrowed" from the funded depreciation account of the provider or from the provider's qualified pension fund.

(3) Where funded depreciation is used for purposes other than improvements, replacement, or expansion of facilities or equipment related to patient care, allowable interest expense is reduced to adjust for offsets not made in prior years for earnings on funded

depreciation. A similar treatment shall be accorded deposits in the provider's qualified pension fund where such deposits are used for other than the purpose of which the fund was established.

(D) Loans Not Reasonably Related to Patient Care. Loans made to finance that portion of the cost of acquisition of a facility that exceed historical cost as determined under Section 206(B) or the cost basis as determined under Section 206(G) are not considered to be for a purpose reasonably related to patient care.

SECTION 208 - BAD DEBTS, CHARITY AND COURTESY ALLOWANCES

208. BAD DEBTS, CHARITY AND COURTESY ALLOWANCES:

(A) Principle. Bad debts, charity, and courtesy allowances are deductions from revenue and are not to be included in allowable cost.

(B) Definitions.

(1) Bad Debts. Bad debts are amounts considered to be uncollectible from accounts and notes receivable which were created or acquired in providing services.

(2) Charity Al lowances. Charity allowances are reductions in charges made by the provider of services because of the indigence or medical indigence of the patient.

(3) Courtesy Allowances. Courtesy allowances are reductions in charges to physicians, clergy, members of religious orders and others for services received from the provider as approved by the policies of the governing body of the provider. Employee fringe benefits, such as hospitalization and personnel health programs, are not considered to be courtesy allowances.

SECTION 209 - COST OF EMPLOYEES' EDUCATIONAL PROGRAM

209. COST OF EMPLOYEES' EDUCATIONAL PROGRAMS:

(A) Principle. An appropriate part of the net cost of bona fide employee's participation in approved professional educational and training programs is an allowable cost. Such professional education or training shall be on less than a full time basis. Restricted training grants received by the center shall be used to offset costs of employee education.

(B) Definitions.

(1) Approved Professional Education Programs. Approved professional educational programs means formally organized or planned programs of study for professionals. These are programs which customarily would be part of a bona fide full-time employee's professional education leading to a diploma or degree in an accredited institution in order to enhance the quality of patient services in a center. These programs shall be licensed where required by law. When licensing is not required, the program shall be approved or accredited by the recognized national professional organization for the discipline.

(2) Training Programs. Training programs mean programs of continuing professional education. These are programs which customarily would be a part of a bona fide full-time employee's continuing professional education in order to maintain a level of proficiency necessary to maintain the quality of patient services in a center. Examples of these programs would be:

(a) periodic staff seminars conducted within the center for the benefit of the center's staff; and

(b) professional seminars conducted somewhere other than within the center which the staff of the center may periodically attend.

(3) Orientation and On-The-Job Training. Orientation and on-the-job training means routine information training of new bona fide employees which is an integral part of their introduction to the responsibilities of their new positions.

(4) Net Cost. The net cost means the reasonable allowable cost of approved professional educational and training programs (i.e., tuition, fees, and other costs) less any reimbursements from grants, tuition, donations, etc., received for educational purposes. Costs of stipends, salaries, and dependent allowances are not allowable cost.

(5) Appropriate Part. Appropriate part means the net cost of these programs apportioned in accordance with the methods set forth in these principles. With respect to approved professional educational programs, costs which exceed the reasonable costs of tuition and fees of equivalent professional educational programs at similar institutions throughout the United States shall not be allowable.

(6) Approving Bodies. Approving bodies are those organizations and associations which recognize the professional stature of educational programs at the national level.

(7) Bona Fide Employee. A bona fide employee means an employee who presently is employed by the provider on a full-time, part-time, or temporary basis, and who has agreed to (and who ultimately does) remain in the full-time employ (minimum 35 hours per week) of the provider for a period of time at least equivalent to the length of the program following the completion of the approved professional educational programs.

(C) Program Participation. Some providers customarily engage in or participate in educational activities including training programs and the employees of a provider may participate in these programs or in other programs. These programs contribute to the quality of patient services within the center to the extent that they maintain or increase the skills and knowledge of the bona fide employees participating in these programs. The intent of the program is to share in the support of the net cost of these educational activities and programs to the extent that they relate to the bona fide employees of the center and the program beneficiaries served by those employees. It is not intended that the program shall participate in increased costs resulting from redistribution of costs from educational institutions or units to patient service centers or units.

SECTION 210 - RESEARCH COSTS

210. RESEARCH COSTS:

(A) Principle. Costs incurred for research purposes, over and above usual patient care, are not includable as allowable costs.

(B) Exception. Where research is conducted in conjunction with and as a part of patient services, the costs of usual patient services are allowable to the extent that such costs are not met by funds provided for the research. Under this principle, however, studies, analyses, surveys, and related activities to serve the provider's administrative and program needs are included as allowable costs.

SECTION 211 - GRANTS, GIFTS, AND INCOME FROM ENDOWMENTS

211. GRANTS, GIFTS, AND INCOME FROM ENDOWMENTS:

(A) Principle. Unrestricted grants, gifts, and income from endowments shall not be deducted from operating costs in computing reimbursable cost. Grants, gifts, or endowment income designated by a donor for paying specific operating costs shall be deducted from the particular operating cost or group of costs. Unearned income shall not be deducted in the year that it is received and not earned, but shall be deducted in the year that it is earned.

(B) Definitions.

(1) Unrestricted Grants, Gifts, Income from Endowments. Unrestricted grants, gifts, and income from endowments are funds, cash or otherwise, given to a provider without restriction by the donor as to their use.

(2) Designated or Restricted Grants, Gifts and Income From Endowments. Designated or restricted grants, gifts and income from endowments are funds, cash or otherwise, which shall be used only for the specific purpose designated by the donor. This does not refer to unrestricted grants, gifts, or income from endowments which have been restricted for a specific purpose by the provider.

(C) Application.

(1) Unrestricted funds, cash or otherwise, are generally the property of the provider to be used in any manner its

management deems appropriate and should not be deducted from operating costs as it would be inequitable to require providers to use unrestricted funds to reduce payments for care. The use of these funds is generally a means of recovering costs which are not otherwise recoverable.

(2) Donor-restricted funds which are designated for paying certain operating expenses shall apply and serve to reduce these costs or groups of costs and benefit all patients who use the services covered by the donation. If such costs are not reduced, the provider would secure reimbursement for the same expense twice; it would be reimbursed through the donor-restricted contributions as well as from patients, other third-party payors and the program.

(3) Public Health Service Grants, DDSA, Chapter I, and any applicable match requirement received by a community mental health-mental retardation center shall be treated as restricted funds and shall be deducted from operating costs in determining a center's allowable cost.

(4) Unrestricted State General Funds in the form of allotments or grants received from the Cabinet for Human Resources shall not be deducted from operating costs in determining reimbursable cost.

SECTION 212 - PURCHASE DISCOUNTS AND ALLOWANCES, AND REFUNDS OF EXPENSE

212. PURCHASE DISCOUNTS AND ALLOWANCES, AND REFUNDS OF EXPENSE:

(A) Principle. Discounts and allowances received on purchases of goods or services are reductions of the costs to which they relate. Similarly, refunds of previous expense payments are reductions of the related expense.

(B) Definitions.

(1) Discounts. Discounts, in general, are reductions granted for the settlement of debts.

(2) Allowances. Allowances are deductions granted for damage, delay, shortage, imperfection, or other causes, excluding discounts and returns.

(3) Refunds. Refunds are amounts paid back or credits allowed because of over collections.

SECTION 213 - COST TO RELATED ORGANIZATIONS

213. COST TO RELATED ORGANIZATIONS:

(A) Principle. Costs applicable to services, facilities, and supplies furnished to the provider by organizations related to the provider by common ownership or control are includable in the allowable cost of the provider at the cost to the related organization. However, such cost shall not exceed the price of comparable services, facilities, or supplies that could be purchased elsewhere by a prudent and cost-conscious buyer.

(B) Definitions.

(1) Related to Provider. Related to the provider means that the provider to a significant extent is associated or affiliated with, has control of, or is controlled by the organization furnishing the services, facilities, or supplies.

(2) Common Ownership. A relationship shall be considered to exist when an individual or individuals possess five (5) percent or more of the ownership or equity in the facility and the institution or organization serving the provider.

(3) Control. Control exists when an individual or an organization has the power, directly or indirectly, to significantly influence or direct the actions or policies of an organization or institution.

(C) Exception. An exception is provided to this general principle if the provider demonstrates by convincing evidence to the satisfaction of the Cabinet: that the supplying organization is a bona fide separate organization; that fifty-one (51) percent or more of the supplier's business activity of the type carried on with the provider is transacted with persons and organizations other than the provider and its related organizations; that there is an open, competitive market for the type of services, facilities, or supplies furnished by the supplier; that the services, facilities, or supplies are those which commonly are obtained by organizations such as the provider from other organizations and are not a basic element of patient care ordinarily furnished directly to patients by such providers; and that the charge to the provider is in line with the charge for such services, facilities, or supplies in the open market and not more than the charge made under comparable circumstances to others by the organization for such services, facilities, or supplies. In such cases, the charge by the supplier to the provider for such services, facilities, or supplies shall be allowable as cost.

SECTION 214 - REASONABLE COST OF PURCHASED SERVICES

214. REASONABLE COST OF PURCHASED SERVICES:

(A) Principle. The reasonable cost of purchased-administrative services furnished under arrangements is an allowable cost, provided the services performed are necessary.

(B) Definitions.

(1) Reasonableness. Reasonableness requires that the cost of the services:

(a) be an amount that would ordinarily be paid for comparable services by comparable providers; and

(b) be pertinent to the operation and sound conduct of the center.

(2) Necessary. Necessary requires that the function be pertinent to the operation and sound conduct of the center.

(C) Application. (1) The Cabinet may establish criteria for use in determining the reasonable allowable cost of purchased services furnished by individuals under arrangements with a provider. It is recognized that providers have a wide variety of arrangements with such individuals. The provision does not require change in the substance of these arrangements.

(2) When services are performed under arrangements on a full-time or regular part-time basis, the reasonable cost of such services may not exceed the amount that would ordinarily be paid for comparable services by comparable providers to full-time or regular part-time employees plus a travel allowance.

(3) When services are performed under arrangements on a limited part-time or intermittent basis (less than fifteen (15) hours per week), the reasonable allowable cost of such services shall be the usual and customary charge for the service prevailing in the area plus a travel allowance.

(4) Costs shall be evaluated so that such costs do not exceed what prudent and cost-conscious management would pay for the given service.

MENTAL HEALTH / MENTAL RETARDATION
COMMUNITY MENTAL HEALTH PROGRAM
SCHEDULE I

ADJUSTMENT AND RECLASSIFICATION OF EXPENSES

VENDOR NAME _____ VENDOR NUMBER _____ PERIOD ENDING _____

	SALARIES	OTHER	SUB TOTAL	ADJUST-MENT	RECLASSI-FICATION	TOTAL
DIRECT SERVICE:	1	2	3	4	5	6
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
11.						
12.						
13.						
14.						
15.						
16.						
17.						
18.						
19.						
20.						
21.						
22.						
23.						
24.						
25.						
26.						
Non-Reimbursable Cost Centers						
27.						
28.						
29.						
30.						
31.						
32.						
33.						
34.						
35.						
36.						
37.						
38.						
39.						
40.						
41. TOTAL MH/MR (SCH B, LINE 22)						

MENTAL HEALTH / MENTAL RETARDATION
COMMUNITY MENTAL HEALTH PROGRAM
SCHEDULE I-I

ADJUSTMENTS TO EXPENSE

VENDOR NAME: _____

VENDOR NUMBER: _____

PERIOD ENDING: _____

1	2	3	4
DESCRIPTION	A/B	INC / <DEC>	SCH. I LINE #
1. TRADE, QUANTITY, TIME AND OTHER DISCOUNTS ON PURCHASES			
2. REBATES AND REFUNDS OF EXPENSES			
3. ADJUSTMENTS RESULTING FROM TRANSACTIONS WITH RELATED ORGANIZATIONS (Reduced to cost)			
4. SALE OF MEDICAL RECORDS AND ABSTRACTS			
5. INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES.			
6. SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS			
7. SALE OF DRUGS TO OTHER THAN PATIENTS			
8. OFFSET OF INVESTMENT INCOME			
9. LOBBYING EXPENSE			
10.			
11.			
12.			
13.			
14.			
15.			
16.			
17.			
18.			
19.			
20.			
21.			
22.			
23.			
24.			
25.			
26.			
27.			
28.			
TOTAL (TRANSFER TO SCHEDULE I, COLUMN 4)			

COLUMN 2, (A) COST (B) REVENUE

MENTAL HEALTH / MENTAL RETARDATION
COMMUNITY MENTAL HEALTH PROGRAM
SCHEDULE I-2

RECLASSIFICATION TO EXPENSE

VENDOR NAME: ______________________________ VENDOR NUMBER: __________

PERIOD ENDING: ________________

DESCRIPTION	SCH. I LINE #	INCREASE	<DECREASE>
1	2	3	4

Transmittal #33
04/01/92

MENTAL HEALTH / MENTAL RETARDATION
COMMUNITY MENTAL HEALTH PROGRAM
SCHEDULE J

COST ALLOCATION STATISTICS

VENDOR NAME: _____ VENDOR NUMBER: _____ PERIOD ENDING: _____

	SQUARE FOOTAGE	SALARIES	MILEAGE	ACCUMULATED COST	ACCUMULATED COST
DIRECT SERVICE:	1	2	3	4	5
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					
14.					
15.					
16.					
17.					
18.					
19.					
20.					
21.					
22.					
23.					
24.					
25.					
26.					
Non-Reimbursable Cost Centers:					
27.					
28.					
29.					
30.					
31.					
32.					
33.					
34.					
35.					
36.					
37.					
38.					
39.					
40.					
41. TOTAL					
42. TOTAL TO ALLOCATE					

MENTAL HEALTH / MENTAL RETARDATION
COMMUNITY MENTAL HEALTH PROGRAM
SCHEDULE J-1
COST ALLOCATION

VENDOR NAME: _____ VENDOR NUMBER: _____ PERIOD ENDING: _____

DIRECT SERVICE:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____
16. _____
17. _____
18. _____
19. _____
20. _____

DIRECT EXPENSE	PLANT EXPENSE	EMPLOYEE BENEFITS	PATIENT TRANS.	SUB TOTAL	MEDICAL RECORDS	OTHER GEN. SERVICE COSTS	GRANTS OFFSET	TOTAL ALLOWABLE COSTS
1	2	3	4	5	6	7	8	9

continued on next page

TRANSMITTAL #33
04/01/92

MENTAL HEALTH / MENT RETARDATION
COMMUNITY MENTAL HEALTH PROGRAM
SCHEDULE J-1 (continued)
COST ALLOCATION

VENDOR NAME: _____ VENDOR NUMBER: _____ PERIOD ENDING: _____

	DIRECT EXPENSE	PLANT EXPENSE	EMPLOYEE BENEFITS	PATIENT TRANS.	SUB TOTAL	MEDICAL RECORDS	OTHER GEN. SERVICE COSTS	GRANTS OFFSET	TOTAL ALLOWABLE COSTS
	1	2	3	4	5	6	7	8	9
DIRECT SERVICE:									
21.									
22.									
23.									
24.									
25.									
26.									
Non-Reimbursable Cost Centers:									
27.									
28.									
29.									
30.									
31.									
32.									
33.									
34.									
35.									
36.									
37.									
38.									
39.									
40.									
41. TOTAL									

TRANSMITTAL #33 04/01/92